DIVISION OF DEVELOPMENTAL DISABILITIES

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MED ERROR REPORT

Please print or type on all sections of the form. Report all med errors which reach a DMH-DD Individual

Immediately report & submit Report Form to DD-Abuse/Neglect, Critical, and Death. All other events submit Report Form within next business day of event or discovery.

1.DMH Use Only *(optional review box, preferred to be completed on line)*	**Event #**
Review Date: **DMH Reviewer:**	

2. Was the event a Critical Incident? ☐Yes ☐No

Was there a report, suspicion or allegation of abuse, neglect or misuse of consumer funds/property? ☐Yes ☐No

3.State Oversight Organization:

Responsible Organization:	***Reporting* Organization Name:** ***Complete only if different from Responsible Organization***
Org ID #:	**Org ID#:**

4.Event Date & Time ____/____/_____ ☐ **Check if date is estimate** Month Day Year	___:___ ☐**AM** ☐**PM** ☐ **Check if time is estimate**
(Complete this section only if different than event date/time) **Discovery Date & Time** ____/____/_____ Month Day Year	___:___ ☐**AM** ☐**PM**

5.Program Category Pertinent to Event *(Check One-DD service the individual was receiving at the time of the event.)*

☐ Case Management ☐ Group Home ☐ Personal Assistant ☐ Supported Employment ☐ Other-Community _____

☐ Day Habilitation ☐ ISL ☐ Respite ☐ Self-Directed Supports ☐ Non-DMH Service

Location of Event (Select all that apply) ☐ Community Outing ☐ Home Visit ☐ Med Room/Home ☐Training Site ☐ Work/School ☐Other Narrative:

Persons Involved

6.Status: Consumer , Staff, Other –specify in space below

Role: Alleged Perpetrator, Complainant , Informant, On Duty Non Witness, Person Making Error, Reporter, Victim, Witness

Last Name *Print or Type*	**First Name**	**Status**	**Role**	**Individual DMH ID #**

☐ *See attached addendum.*

Notifications

7.Notified Types: 911, Agency Administrator, DFS, DHSS, DMH Facility Head, Highway Patrol, Local Law Enforcement , Nurse, Physician, Support Coordinator, Other-Specify

Notified Type	**Contact Name & Title**	**Date**	**Time**
DMH or TCM **Required Notification**			____:____☐AM ☐PM
			____:____☐AM ☐PM
			____:____☐AM ☐PM
			____:____☐AM ☐PM
			____:____☐AM ☐PM
			____:____☐AM ☐PM

Name of Guardian Notified	**Related Individual's Name**	**Date**	**Time**
			____:____☐AM ☐PM
			____:____☐AM ☐PM
			____:____☐AM ☐PM

☐ *See attached addendum.*

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Event Date & Time ____/____/_____ ____:____ ☐**AM** ☐**PM** **Individual DMH ID#:** _____ **Event #**_____

Medication Error

8. Individual's Name:

Error Type *(Select One)*	☐ **Administration**- when there is an incorrect selection and a med is given/not given, in the wrong dosage, form, quantity, route, etc ☐ **Complex**-when a combination of error type occur (administration, dispensing, prescribing) **Dispensing**- Pharmacy, when the incorrect drug, dosage, form, concentration, quantity is formulated and provided for use. **Prescribing**-Physician, incorrect selection of drug, dosage, form, quantity, route, etc, or instructions for use of a drug are wrongly ordered.
Error Category *(Select One)*	☐ Failure to Administer ☐ Wrong Form ☐ Wrong Person ☐ Wrong Time ☐ Wrong Dose ☐ Wrong Medication ☐ Wrong Route ☐ Other _____
Error Severity *(Select One)*	☐ **Minimal:** No treatment or intervention other than monitoring or observation ☐ **Moderate:** Treatment and/or interventions in addition to monitoring or observation ☐ **Serious:** Life threatening and/or permanent adverse consequences
Error Reason *(Select One)*	☐ Charted Incorrectly ☐ Given to Wrong Consumer ☐ New Order Not Flagged ☐ Stated Allergy ☐ Consumer Not Available ☐ Incorrect Dose Calculated ☐ New Order Overlooked ☐ Other: ☐ Error in Transcription ☐ Medication Not Available ☐ No Physician Order ☐ Forgot to Give ☐ Mislabeled ☐ Not Read Correctly
Current Physician Written Order *(Record only meds in error as they appear on order)*	☐ *Service provider may choose to attach current physician order & indicate only meds in error. Check box if provider is attaching the current physician order.*
Error End Date	**Date:** _____ **Time:** _____ ☐**AM** ☐**PM** *(Use only if different from Event Date and Time.)*

Medication Name in Error/Form (Print or Type)	**Quantity** Amount given (0-if med was not given to individual)	**Dosage** Dose given (0-if med was not given to individual)	**Variances** How many consecutive times did the error occur?
☐ *See attached addendum for additional meds in error.*			

Event Description

9.Print or Type - *Describe med error & follow up action.*

Follow Up:

☐ *see attached addendum for additional description*

10.Print Name & Title	**Signature**	**Date**	**Time**
Person Completing Form			____:____ ☐**AM** ☐**PM**
Other/Supervisor			____:____ ☐**AM** ☐**PM**
Other			____:____ ☐**AM** ☐**PM**

Reporting Organization-representative who can be contacted if there is a question pertaining to the completed form.

Staff Name: Phone#: